The Four Villages
Community Health Centre
Working Together for Whole Health

Client Registration Form

Children 0 to 12 years

Four Villages is required by its funder to collect the information below. This information will only be seen by your health care team and will be kept confidential like all your other health care information. It will be used to increase access to services and improve quality of care. **Please complete every field.** Thank you.

Legal Name: _____
First Name Last Name

Date of Birth: _____ / _____ / _____ **Gender:** _____
Day Month Year

Address: _____
Apartment # Building/House # Street Name

_____
City Province Postal Code

Preferred Phone Number: _____
☐ Home ☐ Business ☐ Mobile

Can we leave a detailed message? ☐ Yes ☐ No

Other Phone Number(s): _____
☐ Home ☐ Business ☐ Mobile

Email Address: _____

Do you have any special requests about how we contact you?

_____

Does your child have health insurance? ☐ Yes ☐ No

If yes, please enter their OHIP / IFH / other provincial health insurance number below:

_____ _____ _____ / ____ / _____
Version Code Exp. (year/month/day)

What is the sex on their OHIP card? ☐ M ☐ F ☐ Prefer not to answer

If no, are they in the 3 month waiting period? ☐ Yes ☐ No

Does your child have any allergies? _____

Does your child have an epi-pen? ☐ Yes ☐ No

Name of Parent/Guardian:_____

_____ _____

Phone Number Relationship to Child

Name of Parent/Guardian: _____

_____ _____

Phone Number Relationship to Child

Are there any custody arrangements we should be aware of?

_____

In the past month, was there any day when you or anyone in your family went hungry because you did not have enough money for food?

☐ Yes ☐ No

Please answer the following questions <u>on behalf of</u> your child.

1. **What was your total family income before taxes last year?** Check ONE only.
   - ☐ $0 to $14,999
   - ☐ $15,000 to $19,999
   - ☐ $20,000 to $24,999
   - ☐ $25,000 to $29,999
   - ☐ $30,000 to $34,999
   - ☐ $35,000 to $39,999
   - ☐ $40,000 to $59,999
   - ☐ $60,000 to $89,999
   - ☐ $90,000 to $119,999
   - ☐ $120,000 to $149,999
   - ☐ $150,000 or more
   - ☐ Do not know
   - ☐ Prefer not to answer

2. **How many people does this income support?**

   _____ person(s)

   ☐ Prefer not to answer
   ☐ Do not know

3. **What is your current household composition?** Check ONE only.
   - ☐ Couple with children
   - ☐ Couple without children
   - ☐ Sole member
   - ☐ Grandparents with grandchildren
   - ☐ Extended family
   - ☐ Unrelated housemates
   - ☐ Siblings
   - ☐ Single parent
   - ☐ Other
   - ☐ Prefer not to answer

4. What is your current housing situation? Check ONE only.

- ☐ Not homeless
- ☐ Homeless/no address
- ☐ Shelter
- ☐ Other temporary

5. What is your first language, or "mother tongue"?

☐ English ☐ French Other: _____

6. In what language would you feel most comfortable speaking to your health-care provider?

☐ English ☐ French Other: _____

7. Which of the following best describes your racial or ethnic group? Check ONE only.

- ☐ Asian – East (e.g., Chinese, Japanese, Korean)
- ☐ Asian – South (e.g., Indian, Pakistani, Sri Lankan)
- ☐ Asian – South East (e.g., Malaysian, Filipino, Vietnamese)
- ☐ Black – African (e.g., Ghanaian, Kenyan, Somali)
- ☐ Black – Caribbean (e.g., Barbadian, Jamaican)
- ☐ Black – North American (e.g., Canadian, American)
- ☐ First Nations
- ☐ Indian – Caribbean (e.g., Guyanese with origins in India)
- ☐ Indigenous/Aboriginal
- ☐ Inuit
- ☐ Latin American (e.g., Argentinean, Chilean, Salvadoran)
- ☐ Métis
- ☐ Middle Eastern (e.g., Egyptian, Iranian, Lebanese)
- ☐ White – European (e.g., English, Italian, Portuguese, Russian)
- ☐ White – North American (e.g., Canadian, American)
- ☐ Mixed heritage (e.g., Black – African & White – North American) (Please specify):

  _____
- ☐ Other(s) (Please specify):

  _____
- ☐ Do not know
- ☐ Prefer not to answer

8. Were you born in Canada?

☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

If NO, in what country were you born? _____

What year did you arrive in Canada? _____

9. Do you have any of the following? Check ALL that apply.

- ☐ None
- ☐ Chronic illness
- ☐ Developmental disability
- ☐ Drug or alcohol dependence
- ☐ Learning disability
- ☐ Mental illness
- ☐ Physical disability
- ☐ Sensory disability (i.e. hearing or vision loss)
- ☐ Other (Please specify): _____
- ☐ Do not know
- ☐ Prefer not to answer

10. How would you describe your sense of belonging to your community? (Sense of belonging is feeling like you are part of something, connected and accepted). Check ONE only.

- ☐ Very strong
- ☐ Somewhat strong
- ☐ Somewhat weak
- ☐ Very weak
- ☐ Prefer not to answer
- ☐ Do not know

11. In general, would you say your overall physical health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Do not know
- ☐ Prefer not to answer

12. In general, would you say your overall mental health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Do not know
- ☐ Prefer not to answer

Please email this completed form to kassandra@4villages.on.ca

The Four Villages Community Health Centre
Working Together for Whole Health

Program Participation Waiver
for Physical Activity

1. Have you exercised in the past six months? ☐ Yes ☐ No

2. Do you have any of the following conditions?
   - ☐ Diabetes
   - ☐ Heart condition: _____
   - ☐ Other condition that may affect your ability to participate in the program: _____

3. Do you experience any of the following with exercise?
   - ☐ Shortness of breath
   - ☐ Dizziness
   - ☐ Chest pain

I understand and agree that The Four Villages Community Health Centre (Four Villages) will not have or assume any financial responsibility for any injury I, or any children in my care, may suffer during or resulting from participation in this program.

_____ _____
Name of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Signature of Staff Witness

_____
Names of children / dependents to which this consent applies

The Four Villages Community Health Centre
Working Together for Whole Health

Photo Consent

I give my permission to The Four Villages Community Health Centre (Four Villages) to use my photograph and my child's photograph (if applicable) in their Annual Report to the Community or any other publications and promotional materials which Four Villages may produce in the future.

_____ _____
Name of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Signature of Staff Witness

_____
Names of children / dependents to which this consent applies

Please email this completed form to kassandra@4villages.on.ca